New Patient Integrative Health Intake Form

Name _____

DOB _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Cell Phone _____

Which is the best number to reach you at? _____

Email Address _____

Ethnicity _____ Education Level _____

Form Completion Date _____ Appointment Date _____

1. What are your goals for this visit?

_____

_____

_____

_____

2. Please prioritize your most important health concern today:

Concern	**When/Onset**	**Frequency**	**Severity**
Ex: headaches	*June 2000*	*2times/wk*	*mild/mod/severe*
1.			
2.			
3.			
4.			
5.			

3. If you are not interested in information on complementary and alternative (CAM) medical options (Example: nutrition, acupuncture, massage etc.) Please check one of the following:

☐ Not seeking CAM information

☐ Yes, want more information

4. Please list any prior experiences with complementary or alternative medicine (CAM) care providers. Include what type of services and the type of provider you have seen.

5. On the scale below please circle your interest/exposure to CAM care. This can include seeing physicians and advance practice nurses trained in holistic health. Please circle the number that applies:

1 . . . . . 2 . . . . . 3 . . . . . 4 5

1 = not helpful, would not recommend
2 = mildly helpful, unsure of future use
3 = helpful, would use again
4 = very helpful, definitely use again
5 = highly satisfied, continuing use and recommend to others

6. Do you use CAM care more often than conventional medicine? If yes, please describe. Ex: 6 CAM visits a year, 1 Conventional, etc.

7. Using the same scaling system, please rate your overall satisfaction with conventional medical providers. Please circle the number that applies to your general experience:

1 . . . . . 2 . . . . . 3 . . . . . 4 5

8. **Are there wellness therapies you receive or practice on a routine basis? Massage, acupuncture, yoga, meditation, etc. How often?**

9. **Current medications and doses, including over the counter:**

10. **List all supplements and doses:**

11. **Have you experienced any recent traumatic event? (job loss, divorce, death of loved one, relocation, physical or mental harm)**

12. **Are any of your current health issues changing how you are living your life?**

13. **What are the major stressors in your life?**

14. Whom do you live with?

15. Describe your home health environment:
(light, noise, privacy, comfort, safety, chemical exposure, relationships, etc.)

16. How would you describe your support system?

17. How do you relieve stress?

18. Do you have a spiritual practice?

19. Do you actively practice any religion?

20. What gives meaning and purpose to your life?

21. What interests or hobbies do you have?

22. What leisure activities do you enjoy?

23. What exercise do you do? How often?

24. Any volunteer activities?

25. What is your current or previous occupation?

26. How would you rate your satisfaction with your work? Use a scale of 1 to 5, 5 being the highest.

1 . . . . . 2 . . . . . 3 . . . . . 4 5

27. How would you rate stress in your workplace? Use a scale of 1 to 5, 5 being the highest.

1 . . . . . 2 . . . . . 3 . . . . . 4 5

28. Describe the health of your working environment:
(chemical exposure, safety, sound, light, comfort, the pace, relationships, access to outdoors)

29. Would you describe yourself as experiencing any of the following on a recurrent basis?
Please check all that apply.

- ☐ Fatigue
- ☐ Moodiness/depression
- ☐ Memory problems
- ☐ Compulsive behaviors
- ☐ Sleep problems
- ☐ Appetite or weight change
- ☐ Irritability
- ☐ Lack of enjoyment in life
- ☐ Anxiety

30. If you circled any of the above, what do you do to help yourself (self care)?
Please list only the 3 self care activities that are most important to you.

31. What other information would you like your health care provider to know?

Thank you for completing this form. Please place in the enclosed, stamped envelope and mail to the clinic before your visit date.